DOCUMENT RESUME

ED 417 505 EC 306 246

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TITLE	Preschool Service Delivery Models. Early Childhood Research Institute: Service Utilization. Findings.
INSTITUTION	North Carolina Univ., Chapel Hill. Frank Porter Graham Center.
SPONS AGENCY	Office of Special Education and Rehabilitative Services (ED), Washington, DC.
PUB DATE	1998-03-00
NOTE	16p.
CONTRACT	H024T20002
PUB TYPE	Collected Works - Serials (022) -- Reports - Research (143)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Administrators; *Agency Cooperation; *Cooperative Programs; Decision Making; *Delivery Systems; *Disabilities; *Early Intervention; Integrated Services; Interviews; *Models; Organizational Development; Policy Formation; Preschool Children; Preschool Education; Questionnaires; Resources; School Community Relationship
IDENTIFIERS	Interagency Coordinating Council; *Organizational Structure

ABSTRACT

This study examined the variety of service delivery models used to provide services to preschool children with disabilities in nine diverse communities across three states (Colorado, North Carolina, and Pennsylvania). Information was derived primarily from interviews conducted with community preschool program administrators, service providers, and families, and analysis of policies and interagency questionnaires completed by representatives of the Local Interagency Coordinating Council in each community. Analysis revealed five qualitatively different organizational models: (1) single-program dominated; (2) network of education providers; (3) loosely coupled systems; (4) moderately coupled interagency systems; and (5) comprehensive interagency systems for all children. Each model is described in terms of: overall organizational structure, amount and nature of interagency decision making, target population, and scope and nature of service resources utilized. The study found that eight of the nine communities had made progress in moving from a narrow, insular approach to service delivery. State policy appeared to facilitate development of more coordinated service delivery models, as did interagency structures developed for infant and toddler programs. The study also concluded that federal policy, which aligns requirements for preschool children to those for school-age children, appears to pose a major barrier to the development of comprehensive and coordinated models. Data tables are appended. (Contains 17 references.) (DB)

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PRESCHOOL SERVICE DELIVERY MODELS

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March 1998

INTRODUCTION

Many changes have taken place over the last thirty years in the provision of services to young children with disabilities (Harbin, 1993; Meisels & Shonkoff, 1990; Simeonsson & Bailey, 1990). One of the most monumental forces was the passage of P. L. 99-457 in 1986. Due to political expedience and despite the concerns of professionals, a "seam" was drawn at age three separating services for birth-to-three year olds and three-through-five year olds. For the birth-to-three year olds (infants & toddlers), a new set of provisions was developed requiring services to be comprehensive, coordinated across agencies, and family-centered. However, provisions for three-through-five year olds were "tacked on" to the existing provisions for school age children with disabilities. As a result of numerous complaints from parents and professionals, federal policy makers have attempted to make the Preschool provisions of the law more compatible with the Infant & Toddler provisions by allowing and encouraging interagency coordination and use of the Individualized Family Service Plan (IFSP) during the preschool years. Despite these cosmetic attempts, the reality is that federal legislation has set up two separate programs – one charging interagency responsibility for service delivery and the other primarily vesting responsibility in a single agency – the public school.

In a study of nine communities, Harbin and West (1998) identified six *qualitatively* different Infant & Toddler service delivery models. These models varied with regard to: 1) the amount of interagency coordination; 2) the amount of input into decisions; and 3) the scope of the population served by the model. Through the process of integrating data from multiple studies, Harbin et al. (1998) discovered that the best service outcomes for children and their families generally occurred in the three most coordinated models.

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PURPOSE

The purpose of this paper is to describe the variety of service delivery models being used to provide services to preschool children with disabilities in nine diverse communities across three states. We were interested in determining if there were similarities or differences between those service delivery models developed for Infant & Toddler service systems and those developed for Preschool. Defining the major elements contributing to the Preschool system differences, as well as the impact of different models on service delivery to children and families, were integral aspects of this study. It is hoped that information on the service system models can assist community and state administrators in their efforts to identify their own model of service delivery and to develop more comprehensive service delivery systems, thus more closely achieving the intent of this federal law.

METHODS

The research for this report is *part* of a larger set of studies conducted by the Early Childhood Research Institute on Service Utilization (ECRI:SU). A team of researchers designed and conducted a group of studies that: (1) sought to describe the services provided to young children with disabilities and their families; (2) describe various aspects of service delivery; and (3) identify and explain the multiplicity of factors that are believed to affect services.

Multiple methods were used to collect data related to service provision and utilization at the state, community and program levels. These methods included: service use protocols, scales, and questionnaires; analysis of public policy and budget documents; analysis of Individualized Family Service Plans (IFSPs) and Individual Education Plans (IEPs); interviews with program administrators, focus groups with 45 families, 67 service providers, 37 administrators, and important leaders of each community (N=60), and case studies of 75 children and families, as well as their primary service providers.

Sample. Nine diverse communities located in three socio-demographically diverse states (Colorado, North Carolina, and Pennsylvania) participated in these studies. In each state, a high, medium, and low population density community was selected. Since the states varied considerably with regard to population, the result was nine different levels of population density divided into three broader categories (high, medium, and low). The nine communities ranged in size from a large urban environment with a population of 2,403,676 to a remote rural community with a population of 2,838. See Table 1 in Appendix for additional description of aspects of the nine communities.

Data Collection. Information for this paper was derived primarily from the interviews conducted with community preschool program administrators, service providers and families; analysis of policies, and interagency questionnaires completed by representatives of the Local Interagency Coordinating Council (LICC) in each community also contributed important data for this study. Data from these multiple sources, were reduced and integrated into a single data analysis matrix.

Data Analysis Procedures. Service delivery model typologies were developed through an iterative process of data analysis. Categories were developed for integrating coded data from the sources listed above for use in comparing and contrasting intervention systems in the study communities. The categories consisted of broad components of service delivery (e.g., Child Find, assessment, IEP development, curriculum, use of therapies, transition, etc.). Transcripts from interviews with program administrators were coded based upon the selected categories and the coded information entered into a matrix. This matrix contained descriptions of how children were found, identified, served, and transitioned.

Qualitative data from case studies and focus groups pertaining to these categories were then integrated into a data analytic matrix. Data, with regard to service delivery, reflected the perspectives of parents, service providers, and program administrators. The triangulation (Yin, 1994) of these three perspectives combined to provide a richer and more complete picture of service delivery than any single perspective. We examined the data for patterns in the similarities and differences across communities, comparing communities of similar size and communities within the same state. Through this analytic process of the individual elements of service delivery (e.g., child find, assessment), broader patterns of how services were delivered appeared to emerge. Central to these broader patterns was the level of involvement of the various agencies in decision-making about service delivery. Subsequently, a second (reduced) data matrix led to the delineation of early intervention service system typologies.

The background of the analysts is relevant in qualitative analysis because their perspective is brought to the interpretation of data. The principal investigator of this study brings with her 15 years experience in research on early intervention policy, service delivery and interagency coordination, preceded by work as a teacher of young children with disabilities. In addition, Dr. Harbin has spent many years in providing technical assistance to state and local policy-makers in setting up service systems that reflect recommended practices. The research assistant has 10 years of experience in working with young children both with and without special needs, and with their families. Both of these individuals are familiar with the literature regarding recommended practices. These recognized practices served as standards by which elements of the service delivery process and model were examined. See for example: Bailey, 1987; Barber, Turnbull, Behr, & Kerns, 1988; Bruder, 1996; Bruder & Chandler, 1993; Dunst, 1985; Dunst, Johanson, Trivette, & Hamby, 1991; Fewell & Vadasy, 1986; McWilliam, 1991; McWilliam & Strain, 1993; Odom & McLean, 1993; Rosenberg, 1977; Vincent & Beckett, 1993.

FINDINGS

Service Delivery Models: How Services are Organized

Analysis of the preschool service delivery models in the nine study communities revealed five *qualitatively different* organizational models for the delivery of services to preschool children with disabilities. Several key elements are addressed within each model: 1) the overall organizational structure that guides service delivery; 2) the amount and nature of interagency decision-making; 3) the scope of the target population; and 4) the scope and nature of service resources that are utilized. The interaction of these elements shape the scope and comprehensiveness of the service delivery systems. Table 2 in the Appendix presents a comparison of the Preeschool Service Delivery Models. It is interesting to note that there were six Infant & Toddler Service Delivery Models. The biggest difference between the Infant & Toddler and Preschool models is the prominence of the school system as the lead agency in the Preschool models. With the exception of one of the Preschool service delivery models, the public school dominated the design of the system.

Single-Program Dominated. This model is most similar to the preschool service delivery models existing prior to the enactment of P. L. 99-457 (now included in the Individuals with Disabilities Education Act). A single educational program focuses on addressing the cognitive, social, language, and motor needs of the child. Interventionists in these programs, usually preschool special education

teachers, seldom see family needs as part of their classroom domain.

In the Single-Program Dominated service delivery model, all other programs are viewed as supplementary to the program or classroom that provides educational intervention. The teacher recognizes that the child may have medical needs or that the family has housing needs, but these issues are seen as *outside* the focus of the preschool program. There might be some instances in which the teacher feels the need to converse with a professional or administrator in another agency (e.g., the Health Department); however, these interactions and arrangements with professionals from other agencies are almost always informal in nature and rarely occur. Since the teacher spends most of his or her time with the child in the classroom, little time is available to work and coordinate with other professionals. Ongoing coordination for child and family needs is not seen as a priority, either for philosophical or practical reasons.

In a Single-Program Dominated model, the target for service delivery is the education of children with identifiable disabilities or developmental delays. Therefore, the array of services consists of those services provided by the educational intervention program and perhaps a few other programs that are designed primarily for the education of children with disabilities. Placement options usually are limited to the district preschool program. In some localities, the school system subcontracts all services to Headstart or a private (or quasi-private) program that historically has served only children with disabilities. There is little emphasis on inclusion. Thus, in this model the public school either provides services in their own primarily segregated classrooms, or subcontracts to some other provider. One of the main features of this service delivery model is the lack of coordination with other educational programs. This occurs for one of two reasons. First, the size of the community may be small enough so that the school decides to use an existing provider and not develop alternative placements. The second situation occurs when there are public school preschool classrooms for children with disabilities and classrooms for other children as well (e.g., Headstart). However, both programs operate autonomously with little or no coordination.

Network of Education Providers. In this model, a network of educational programs (e.g., public school, Headstart, private intervention programs) has begun to meet together and engage in some dialogue and cooperative planning. In many instances, the provider agencies or programs are trying to determine how to work together, as well as trying to decide the appropriate focus for their activities. In the Network model there is also an increased awareness of non-educational programs, agencies, and services within the community. Although the primary focus of this model is networking among education programs, programs from various agencies (e.g., health, social services, mental health), while continuing to operate independently, are beginning to meet and communicate occasionally with the education providers. If coordination between one of the primary educational intervention providers (i.e., school, Headstart) and a non-educational agency (e.g., health, social services), takes place, however, it is around the needs of an individual child rather than at the "system" level.

In a Network model, each agency or program continues to autonomously plan and carry out its own services; however, each becomes more *aware* of the services provided by other programs' agencies as well. The informal linkages and relationships are strengthened, and as a result, this Network of Multiple Education Providers may develop some formal agreements. However, since these agency representatives are accustomed to functioning autonomously, their first efforts

at cooperative planning often focus on dividing service responsibilities in order to eliminate overlaps and to operate more efficiently.

The Network of Multiple Education Providers primarily is interested in the education of children with disabilities, and the membership of the group is influenced by its lead agency, the public school, and the programs with which they have the most natural linkages. Thus, agencies linked to meeting the educational needs of children (e.g., Head Start, private programs for children with disabilities, and public and private preschools) are most likely to be part of the network. In this model, the public school has become interested in using a variety of specialized and inclusive placements, which helps to provide impetus for a Network of providers to meet.

There may be a Local Interagency Coordinating Council (LICC) which provides an impetus for the efforts at coordinating services. However, the public school often dominates decision-making by setting the agenda and laying out the parameters regarding the choices and decisions to be made by the group. The justification for this dominance is the need to comply with the federal law. Accordingly, the Network of Multiple Education Providers (and non-educational agencies if they are present) recognizes the public school as the agency responsible for abiding by the law and making things work,. All education providers see the law as having relevance to them regardless if they are part of the school system. Other agencies are seen as supplementary to service delivery.

Loosely Coupled System. The educational programs in the Loosely Coupled System service delivery model exhibit stronger connections than in the models described previously. Non-education agencies see it as the "public School's law – not ours". The Coordinator of the Preschool Special Education Program usually provides leadership for coordinated planning around the child's education, and individuals from different education programs work together closely. Private education programs and providers are integrated into the cooperative decision-making and service delivery process, and participate in discussions and share common understandings of such terms as screening, assessment, and inclusion. Rarely do non-educational agencies (e.g., Health, Social Services) participate in the development of IEPs or the selection of needed resources and placements for the child or family. The array of programs and resources in this model focuses on meeting the educational needs of children with disabilities, but may include some planning for children at-risk for disabilities as well.

***Moderately Coupled Interagency System* (Moderately Coupled System with Strongly Coupled Education System).** This model exhibits a higher level of connectedness and cohesion than the previous models. In the Moderately Coupled Interagency model, several educational agencies are seen as responsible for coordinated planning and service delivery. Also, agencies other than those that provide educational intervention (e.g., Health, Mental Health) are seen as providing an important perspective for planning the intervention system and as possessing knowledge and resources that are important to children and families. Although in reality the public school has final decision-making authority, all education providers, contribute fairly equally to decision-making, and include non-education agencies in the decision-making process as well. As a result, although the education of the child with disabilities is still the focus of this model, the array of programs includes those designed to meet not only the educational needs of the child, but some broader needs as well. In addition, this model focuses on developing a system of services not only for preschool children with disabilities, but for children at risk as well.

Comprehensive Interagency System for All Children. This model differs from the previous models in two important ways: 1) the scope of the population to be addressed and hence the number and array of agencies that are involved in coordinated decision-making; and 2) its organizational structure.

In the Comprehensive Interagency System model, participants have decided to plan a system of services for all young children and their families within the community. This philosophy of universal services recognizes that all children and families belong to the community, and thus it is the community's responsibility to support and facilitate the development of all children and support all families in this endeavor. However, because education of the child is seen as important in preventing risk and enhancing the development of those with disabilities, an emphasis of the system continues to be the *education* of the child, with educational placements and services of primary importance. A coordinated preschool system of various programs and placements is visible within the community, and is accessible for all preschool children, including those with special needs. In addition, there is more emphasis in this model on the non-educational needs of children and the needs of their families than in the previous model.

Individuals in these communities believe providing universal services will have four important results. First, children in need will be identified and receive services as soon as possible (early identification). Second, because all children receive services, educational problems can be minimized or avoided (prevention). Third, there is no stigma for receiving services, because it is viewed as natural in the community to take advantage of resources; there is nothing wrong with help seekers, help is their right and to their advantage. Fourth, it is easier to access natural settings, resources and activities. As a result of this broader vision of the service system, there are more agencies and programs involved in order to address the scope of needs of all children and families within the community. This model also often includes services from programs or organizations that are clearly imbedded in the larger community (e.g., Inter-Faith Council) which usually are not included in the more disability-focused service delivery models discussed previously.

The second major difference between this model and the moderately coupled system lies in the organizational structure. In the Comprehensive Interagency System model, the local coordinating council is considered the lead agency, and often contains a broader representation of the community (e.g., business sector, city government, etc.). In addition to operating as the lead agency for service planning, the group might also receive funding, making it, at times, the fiscal agent as well. The group has visibility within the community, often having a formal name (e.g., Echo Council, or Partnership for Children) and is recognized as the primary force and vehicle for meeting child and family needs, while individual programs are seen as supplementary and supportive to the cause. In order to maximize resources, all programs cooperatively participate in decision-making. To supplement community resources and services (e.g., development of a family center), the council plans and write grants to foundations, state agencies, and federal agencies for demonstration projects. In addition, when one of the local agencies must submit a grant to its funding agent, the local council has as much or more input into the design and conceptualization of the grant as the submitting agency.

This comprehensive approach requires community acceptance and support, as well as strong linkages between traditional public agencies (Health, Education, Developmental Disabilities, and Social Services), the business community (e.g., Chamber of Commerce), and

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the local government officials (e.g., Town Manager, Mayor). It also requires a group of cooperative leaders that have the skills to build bridges between groups and constituencies and to develop working teams.

Comparison of Service Delivery Models by State

In an analysis of Infant & Toddler service delivery models, Harbin and West (1998) noted the link between the service delivery model operating in the community and the contents of state policy. Table 3 (in the appendix) indicates the possible influence of state policy on the development of the service delivery model at the community level.

State policy makers in **Colorado** have emphasized interagency coordination through training and financial incentives to local communities since the late 1970s. Historically, the Colorado Department of Education has emphasized the development of services for preschool children. The system developed at the state level has emphasized interagency coordination, inclusion, and being responsive to families' concerns. Consequently, the Preschool programs in Colorado were among the most coordinated, inclusive, and family-friendly service delivery models in the study.

In **North Carolina** in the last few years, state policy makers in the Department of Public Instruction have sponsored training of a community interagency teams in order to improve transition. Prior to the enactment of P. L. 99-457, there was no legislation entitling services to Preschool children in North Carolina and many of the services were provided through another state agency. Many of the programs in North Carolina at the time of the enactment of P. L. 99-457 were Single Program oriented models despite which agency provided the services. Interviews with local program coordinators in North Carolina revealed that their participation in the Local Interagency Council, as well as the Consortium (a local interagency structure charged with determining eligibility for the Infant & Toddler Programs) had greatly increased their efforts in coordinating with other agencies.

Pennsylvania had a state entitlement to preschool services prior to the enactment of P. L. 99-457. Pennsylvania's policies do not require or promote interagency coordination.

Comparison of Infant & Toddler and Preschool Models

As reported in the introduction to this report, the authors (1998) identified six Infant & Toddler service delivery models, whereas only five Preschool models were identified. There were four communities using the most coordinated Infant & Toddler models (three from North Carolina and one from Colorado), whereas there were three communities using the most coordinated Preschool models (two from Colorado and one from North Carolina).

Table 4 (see appendix) presents a comparison of the service delivery models used in each community for the two age groups. In two **Colorado** communities the Infant & Toddler and Preschool models are the same; for the third community the Preschool model is the more coordinated of the two service delivery models. With regard to **North Carolina**, the Infant & Toddler models are more coordinated than the Preschool models. Finally, in **Pennsylvania**, one of the models is the same, while in one community the Infant & Toddler model is slightly more coordinated and in the final community the Preschool model is more coordinated.

In general, in all of the Preschool models the primary emphasis was on the education of the child. The Preschool requirements within the federal legislation (Part B of IDEA) exerted a powerful force in the development of the service delivery model, resulting in the mentality that the "school system is responsible." Consequently, it was rare for the school system to share leadership

in decision-making. Even in the two communities that used a Moderately Coupled service delivery model, the school system (and the federal policies) were more prominent in decision-making than was the Infant & Toddler lead agency in that same model. Flexibility was an important factor. Most individuals perceived an inflexible set of regulations; this was exacerbated by the "mentality" of the public school model, which sees itself as solely responsible. To overcome this insular, less flexible view required local program leaders who were themselves more flexible. Even then, two of the three Preschool Coordinators in the most coordinated models felt like they were swimming against the tide (i.e., the culture and expectations of their agency).

CONCLUSIONS

Eight of the nine communities had made progress in moving away from a narrower, more insular approach to service delivery for preschool children. Although this progress is important, several of the communities have farther to go in developing a comprehensive and coordinated system, which is more in line with recommended practice. It appears that state policy can facilitate the development of more coordinated service delivery models. It is also interesting that the interagency structures developed for the Infant & Toddler programs also influenced the degree of coordination of Preschool models. Furthermore, the vision and flexibility (or lack of it) of the local Preschool Coordinator was also an instrumental factor in enhancing coordinated service delivery.

Finally, federal policy which aligns requirements for Preschool children to those for school age children, appears to pose a major barrier to the development of comprehensive and coordinated models. This finding, in concert with findings from focus groups of 45 families and case studies of 75 families, indicate dissatisfaction with the existence of two separate programs for the two age groups (Infant & Toddler and Preschool). The "seam" that was drawn creating two sets of federal requirements, and hence two separate programs, is detrimental to the development of quality preschool models and should be eliminated.

REFERENCES

Bailey, D. B. (1987). Collaborative goal-setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7(2), 59-71.

Barber, P. A., Turnbull, A. P., Behr, S. K., & Kerns, G. M. (1988). A family systems perspective on early childhood special education. In S. L. Odom & M. B. Karnes (Eds.), Early intervention for infants and children with handicaps (pp. 198-199). Baltimore: Paul H. Brookes.

Bruder, M. B. (1996). Interdisciplinary collaboration in service delivery. In R. A. McWilliam (Ed.), Rethinking pull-out services in early intervention: A professional resource (pp. 27-48). Baltimore, MD: Paul H. Brookes.

Bruder, M. B., & Chandler, L. K. (1993). Transition. In S. L. Odom & M. McLean (co-chairpersons), DEC recommended practices: Indicators of quality in programs for infants and young children with special needs and their families, (pp. 96-104). DEC Task Force on Recommended Practices: The Council for Exceptional Children.

Dunst, C. J. (1985). Rethinking early intervention. Analysis and Intervention in Developmental Disabilities, 5, 165-201.

Dunst, C. J., Johanson, C., Trivette, C. M., & Hamby, D. W. (1991). Family-oriented early intervention policies and practices: Family-centered or not? Exceptional Children, 58, 115-126.

Fewell, R., & Vadasy, P. (Eds.). (1986). Families of handicapped children: Needs and supports across the life span. Austin, TX: PRO-ED.

Harbin, G. L. (1993). Family issues of children with disabilities: How research and theory have modified practice in intervention. In N. J. Anastasiow & S. Harel (Eds.), At-risk infants: Interventions, families and research (pp. 101-114). Baltimore, MD: Paul H. Brookes Publishing Co.

Harbin, G. L., Kochanek, T. T., McWilliam, R. A., Gallagher, J. J., Shaw, D., Tocci, L., Buka, S. L., West, T., Sideris, J., & Clark, K. (1998). Implementing federal policy for young children with disabilities: How are we doing?. Chapel Hill, NC: Early Childhood Research Institute on Service Utilization, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Harbin, G. L. and West, T. (1998). Early Intervention Service Delivery Models and Their Impact on Children and Families. Chapel Hill, N.C.: Early Childhood Research Institute on Service Utilization; Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

McWilliam, R. A. (1991). Integrated therapy: Why are we still debating? INTAC Tribune, 4(9), 1-3.

McWilliam, R. A., & Strain, P. S. (1993). Service delivery models. In S. L. Odom & M. McLean (co-chairpersons), DEC recommended practices: Indicators of quality in programs for infants and young children with special needs and their families, (pp. 40-46). DEC Task Force on Recommended Practices: The Council for Exceptional Children.

Meisels, S. J., & Shonkoff, J. P. (Eds.). (1990). Handbook of early childhood intervention. New York: Cambridge University Press.

BEST COPY AVAILABLE

Odom, S. L., & McLean, M. (co-chairpersons). (1993). DEC recommended practices: Indicators of quality in programs for infants and young children with special needs and their families. DEC Task Force on Recommended Practices: The Council for Exceptional Children.

Rosenberg, S. (1977). Family and parent variables affecting outcomes of a parent-mediated intervention. Unpublished doctoral dissertation, George Peabody College for Teachers, Nashville, TN.

Simeonsson, R. J., & Bailey, J. B. (1990). Family dimensions in early intervention. In S. J. Meisels & J. P. Shonkoff (Eds.), Handbook of early childhood intervention (pp. 428-444). New York: Cambridge University Press.

Vincent, L. J., & Beckett, J. A. (1993). Family participation. In S. L. Odom & M. McLean (co-chairpersons), DEC recommended practices: Indicators of quality in programs for infants and young children with special needs and their families, (pp. 19-25). DEC Task Force on Recommended Practices: The Council for Exceptional Children.

APPENDIX

Table 1
Descriptive Portrait of Study Communities

	COLORADO			NORTH CAROLINA			PENNSYLVANIA		
	HI	**MOD**	**LOW**	**HI**	**MOD**	**LOW**	**HI**	**MOD**	**LOW**
Total Population	225,339	32,273	6,007	347,420	59,013	61,704	1,336,446	89,994	78,097
Total Minority (%)	10.5	13.9	25.1	28.6	19.9	5.7	13.1	2.5	0.6
% Child Poverty	9.5	19.8	16.4	14.3	17.7	12.9	17.1	21.0	18.6
Per Capita Income	$17,359.	$9,971.	$11,269.	$18,117.	$16,274.	$13,370.	$15,115.	$10,260.	$10,430.
Children in Single Parent Families (%)	16.4	28.5	23.8	23.0	20.0	15.0	23.9	16.7	16.4
Low Birthweight Rate (%)	6.4	9.3	15.8	8.6	7.7	6.0	8.0	6.0	6.1

Table 2

Preschool Service System Models

	Single Program Dominated	Network of Education Providers	*Loosely Coupled Interagency System* (Primary Coordination with Education Providers, Secondary Coord. with Other Agencies)	*Moderately Coupled Interagency System*	Comprehensive Interagency System for All Children
Visual Depictions					
Organizational Structure	Public schools provide all educational services or subcontract to a single provider (e.g., Headstart) to provide all educational services. Public schools coordinate with other agencies (e.g., health, Social Services) that provide non-educational services "when necessary". Linkages exist with other agencies but primarily for referral purposes. If there is an LICC, it is used primarily for agencies to inform one another of plans and activities. Rarely any cooperative planning.	A network of educational programs has begun to meet and engage in limited cooperative planning. Non-education agencies (e.g., Health, Social Services) may be part of this planning group (LICC), but involvement of these agencies focuses on assisting with the education process (i.e. screening, assessment, provision of therapies).	Primary coordination occurs between and among two or more educational intervention programs. LICC is instrumental in cooperative design of procedures/components to be used across all providers (e.g., IFSP, assessment, intervention). Focus is on educational intervention process more than total system (i.e., coordination of educational intervention with health and welfare programs is secondary).	Strong linkages among school and other educational programs to provide services in a similar manner. Multiple educational intervention programs work closely as if they are part of a single program. In addition, the LICC has developed a vision of an array of services to meet the needs of children (primarily) and their families (secondarily). Therefore, other agencies (health, social services) participate in planning in meaningful way.	LICC is composed of a broad array of child and family services. The LICC has developed a broad vision for a cohesive system of services to meet the needs of all children and their families. All programs and providers (public and private) share common values and have participated in planning this broad system. The LICC serves as the lead agency and write grants to supplement existing resources.
Decision-Making	Public school or agency sub-contracted to (e.g., Head Start) is primary decision-maker for child education services. School may be open to suggestions, but has final say.	Public school dominates decision-making for child education, although the primary providers of educational intervention may participate in some cooperative planning. All agencies on the LICC may engage in cooperative planning around areas such as Public Awareness, Child Find and screening. Decisions often focus on dividing up responsibilities.	The multiple educational intervention programs provide leadership/direction for LICC decisions (educational intervention predominates). Other agencies contribute, but secondarily.	Public School facilitates coordinated planning among education providers and other agencies. Agencies contribute fairly equally to decision-making.	Shared decision-making among interagency group with educational providers having an integral role in the collaborative planning and implementation.
Scope of Target	Education of child with disabilities.	Primary emphasis on education of the child with disabilities.	Primary emphasis on education of child with disabilities, may have a secondary emphasis on education of the child at-risk.	Primary emphasis on education of the child with disabilities and some emphasis on needs of child and his family beyond education (e.g., health, housing). Secondary emphasis on education of the child at risk and an occasional focus on all children in community.	Population addressed is all young children and their families. There is a strong emphasis on the education of the child, but also concerned about broader needs as well (e.g., health, basic needs, etc.).
Scope of Resources (Array)	School provides classroom intervention or subcontracts to a single provider (e.g. Head Start) for educational services.	Emphasis on educational needs of child. An array of public and private educational and therapeutic (OT, PT) sites. Occasionally refers child to selected non-educational services (e.g., Health Dept.).	An array of public and private educational and therapeutic (OT, PT) sites. A limited number of non-educational services and resources are recognized.	An array of public and private educational and therapeutic (OT, PT) sites. A moderate array of non-educational services and resources are recognized and used.	A comprehensive array including specialized and natural community resources to meet various child and family needs.

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TABLE 3
COMPARISON OF SERVICE DELIVERY MODELS BY STATE

	#1	#2	#3	#4	#5
Colorado			1	1	1
North Carolina		2		1	
Pennsylvania	1	1	1		

TABLE 4
COMPARISON OF INFANT & TODDLER AND PRESCHOOL MODELS BY COMMUNITY

	Infant & Toddler	Preschool
Colorado		
High	Loosely Coupled	Loosely Coupled
Med	Comprehensive	Comprehensive
Low	Single Program	Moderately Coupled
North Carolina		
High	Moderately Coupled	Network
Med	Strongly Coupled	Moderately Coupled
Low	Moderately Coupled	Network
Pennsylvania		
High	Network	Network
Med	Single Program	Loosely Coupled
Low	Network	Single Program

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